

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/25/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGE DALE			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGE DALE, TN 37315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During Complaint Investigation #TN30063 completed July 24 to July 25, 2012, no deficiencies were cited related to the complaint under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Carla K. Youngberg

TITLE

Administrator

(X6) DATE

8-08-12

STATE FORM

6899

NSDZ11

If continuation sheet 1 of 1

AUG 09 2012